

## ALCOHOLIC INFLUENCE REPORT

INSTALLATION		VIOLATION REPORT NO.		ACCIDENT REPORT NO.	
DATE, TIME AND LOCATION OF ACCIDENT OR INCIDENT			DATE AND TIME IN CUSTODY		APPREHENDING OFFICER
NAME OF SUBJECT			GRADE/CATEGORY		SSN
UNIT OF ASSIGNMENT/ADDRESS				<input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN	
AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	APPROX. WEIGHT	OPERATOR'S LICENSE NO.		STATE

*Check all applicable boxes describing conditions observed, i.e., more than one box may be checked to describe conditions observed.*

### SECTION I - OBSERVATIONS

MADE BY <i>(Name, grade, SSN &amp; organization)</i>		WITNESSED BY <i>(Name, grade, SSN &amp; organization)</i>	
<b>CLOTHES</b> <i>(Describe type &amp; color)</i>	HAT OR CAP		
	JACKET OR COAT		
	SHIRT OR DRESS		
	PANTS OR SKIRT		
	CONDITION	<input type="checkbox"/> Disorderly <input type="checkbox"/> Disarranged <input type="checkbox"/> Soiled <input type="checkbox"/> Mussed <input type="checkbox"/> Orderly	
<b>BREATH</b>	ODOR OF ALCOHOLIC BEVERAGE <input type="checkbox"/> Strong <input type="checkbox"/> Moderate <input type="checkbox"/> Faint <input type="checkbox"/> None		
<b>ATTITUDE</b>	<input type="checkbox"/> Excited <input type="checkbox"/> Hilarious <input type="checkbox"/> Talkative <input type="checkbox"/> Carefree <input type="checkbox"/> Sleepy <input type="checkbox"/> Profanity <input type="checkbox"/> Combative <input type="checkbox"/> Indifferent <input type="checkbox"/> Insulting <input type="checkbox"/> Cocky <input type="checkbox"/> Cooperative <input type="checkbox"/> Polite		
<b>UNUSUAL ACTIONS</b>	<input type="checkbox"/> Hiccoughing <input type="checkbox"/> Belching <input type="checkbox"/> Vomiting <input type="checkbox"/> Fighting <input type="checkbox"/> Crying <input type="checkbox"/> Laughing		
<b>SPEECH</b>	<input type="checkbox"/> Not understandable <input type="checkbox"/> Mumbled <input type="checkbox"/> Slurred <input type="checkbox"/> Mush Mouthed <input type="checkbox"/> Confused <input type="checkbox"/> Thick Tongued <input type="checkbox"/> Stuttered <input type="checkbox"/> Accent <input type="checkbox"/> Fair <input type="checkbox"/> Good		
SPONTANEOUS ACTS <i>(Statements, walking, turning, etc.)</i>			
INDICATE BRIEFLY WHAT FIRST LED YOU TO SUSPECT ALCOHOLIC INFLUENCE		SIGNS OR COMPLAINT OF ILLNESS OR INJURY	

### SECTION II - PERFORMANCE TESTS *(Warning of rights in accordance with separate departmental policy is required for military personnel)*

ADMINISTERED BY <i>(Name, grade, SSN &amp; organization)</i>		DATE & TIME TESTS PERFORMED
<b>BALANCE</b>	<input type="checkbox"/> Falling <input type="checkbox"/> Needed Support <input type="checkbox"/> Wobbling <input type="checkbox"/> Swaying <input type="checkbox"/> Unsure <input type="checkbox"/> Sure	
<b>WALKING</b>	<input type="checkbox"/> Falling <input type="checkbox"/> Staggering <input type="checkbox"/> Stumbling <input type="checkbox"/> Swaying <input type="checkbox"/> Unsure <input type="checkbox"/> Sure	
<b>TURNING</b>	<input type="checkbox"/> Falling <input type="checkbox"/> Staggering <input type="checkbox"/> Hesitant <input type="checkbox"/> Swaying <input type="checkbox"/> Unsure <input type="checkbox"/> Sure	
<b>FINGER TO NOSE</b>	RIGHT <input type="checkbox"/> Completely missed <input type="checkbox"/> Hesitant <input type="checkbox"/> Sure	LEFT <input type="checkbox"/> Completely missed <input type="checkbox"/> Hesitant <input type="checkbox"/> Sure
<b>COINS</b>	<input type="checkbox"/> Unable <input type="checkbox"/> Fumbling <input type="checkbox"/> Slow <input type="checkbox"/> Sure <input type="checkbox"/> Other	BALANCE DURING COIN TEST
ABILITY TO UNDERSTAND INSTRUCTIONS <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good	EFFECTS OF ALCOHOL <input type="checkbox"/> Extreme <input type="checkbox"/> Obvious <input type="checkbox"/> Slight <input type="checkbox"/> None    ABILITY TO DRIVE <input type="checkbox"/> Unfit <input type="checkbox"/> Fit	

REMARKS
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**SECTION III - INTERVIEW** (Warning of rights in accordance with separate departmental policy is required for all personnel)

Were you operating a vehicle? \_\_\_\_\_ Where were you going? \_\_\_\_\_  
 What street or highway were you on? \_\_\_\_\_ Direction of travel? \_\_\_\_\_  
 Where did you start from? \_\_\_\_\_ What time did you start? \_\_\_\_\_ What time is it now? \_\_\_\_\_  
 What city (county) are you in now? \_\_\_\_\_ What is the date? \_\_\_\_\_ What day of the week is it? \_\_\_\_\_

<b>INTERVIEWER TO FILL IN ACTUAL</b>	TIME	DAY	DATE	INTERVIEWER'S NAME
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When did you last eat? \_\_\_\_\_ What did you eat? \_\_\_\_\_  
 What were you doing during the last three hours? \_\_\_\_\_  
 Have you been drinking? \_\_\_\_\_ What? \_\_\_\_\_ How much? \_\_\_\_\_ Where? \_\_\_\_\_  
 Time started? \_\_\_\_\_ Time stopped? \_\_\_\_\_ Are you under the influence of an alcoholic beverage now? \_\_\_\_\_  
 What is your occupation? \_\_\_\_\_ When did you last work? \_\_\_\_\_  
 Do you have any physical defects? \_\_\_\_\_ If so, what's wrong? \_\_\_\_\_  
 Do you limp? \_\_\_\_\_ Have you been injured lately? \_\_\_\_\_ If so, what's wrong? \_\_\_\_\_  
 Are you ill? \_\_\_\_\_ If so, what's wrong? \_\_\_\_\_  
 Did you get a bump on the head? \_\_\_\_\_ Were you involved in an accident today? \_\_\_\_\_ Have you had any alcoholic beverage since the accident? \_\_\_\_\_  
 If so, what? \_\_\_\_\_ Where? \_\_\_\_\_ How much? \_\_\_\_\_ When? \_\_\_\_\_  
 Have you seen a doctor or dentist lately? \_\_\_\_\_ If so, who? \_\_\_\_\_ When? \_\_\_\_\_  
 What for? \_\_\_\_\_ Are you taking tranquilizers, pills or medicines of any kind? \_\_\_\_\_  
 If so, what kind? (Get sample) \_\_\_\_\_ Last dose? \_\_\_\_\_ Do you have epilepsy? \_\_\_\_\_ Diabetes? \_\_\_\_\_  
 Do you take insulin? \_\_\_\_\_ If so, last dose? \_\_\_\_\_ Have you had any injections of any other drugs recently? \_\_\_\_\_  
 If so, what for? \_\_\_\_\_ What kind of drug? \_\_\_\_\_ Last dose? \_\_\_\_\_  
 When did you last sleep? \_\_\_\_\_ How much sleep did you have? \_\_\_\_\_ Are you wearing false teeth? \_\_\_\_\_ Glass eye? \_\_\_\_\_

**HANDWRITING SPECIMEN** (Signature and/or anything he chooses)

**SECTION IV - CHEMICAL TEST DATA**

TYPE OF SPECIMEN <input type="checkbox"/> Blood <input type="checkbox"/> Breath <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Other	TIME, DATE AND LOCATION OF TEST
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ADMINISTERED BY (Name, grade, SSN & organization)	TEST RESULT
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IF TEST REFUSED, OR UNABLE TO BE ADMINISTERED, STATE REASON

**SECTION V - VIDEO TAPE, MOTION PICTURE, VOICE RECORDINGS**

TYPE COVERAGE <input type="checkbox"/> Video tape <input type="checkbox"/> Motion Picture <input type="checkbox"/> Voice	SCOPE OF COVERAGE <input type="checkbox"/> Observation <input type="checkbox"/> Performance test <input type="checkbox"/> Interview
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TAKEN BY (Name, grade, SSN & organization)	REFERENCE CODE
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**SECTION VI - SUPPLEMENTARY DATA**

	NAME	ADDRESS	TELEPHONE NO.	CONDITION
<b>WITNESSES</b>				
<b>PASSENGERS IN SUSPECT'S VEHICLE</b>				